# NC DMA Pharmacy Request for Prior Approval - Leukotriene Modifiers

**Recipient Information** **DMA-3103**

1. Recipient Last Name:_____ 2. First Name:_____
3. Recipient ID #_____ 4. Recipient Date of Birth:_____ 5. Recipient Gender:_____

**Payer Information**

6. Is this a Medicaid or Health Choice Request? Medicaid: ☐ Health Choice: ☐

**Prescriber Information**

7. Prescribing Provider #:_____ NPI: ☐ *or* Atypical: ☐
8. Prescriber DEA #: _____
Requester Contact Information
Name:_____ Phone #:_____ Ext:_____

**Drug Information**

9. Drug Name: ☐ Accolate ☐ Montelukast ☐ Singulair ☐ Zafirlukast (generic for Accolate) ☐ Zyflo/Zyflo CR
10. Strength: _____ 11. Quantity Per 30 Days: _____
12. Length of Therapy (in days): ☐ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ 365 ☐ Other:_____

**Clinical Information**

1. ☐ If requesting a non-preferred drug, list preferred drugs failed:_____

**Asthma -Accolate, Zyflo, Singulair and montelukast**

2. Does the patient have a diagnosis of Asthma? ☐ Yes ☐ No
3. Does the patient have a documented adverse reaction or contraindication to inhaled steroids? ☐ Yes ☐ No
4. Does the patient have growth suppression due to inhaled corticosteroids? ☐ Yes ☐ No
5. Is the patient on a medium dose inhaled corticosteroid and needs a Leukotriene Receptor Antagonist or 5-Lipooxygenase Inhibitor to achieve control (Step 4 or higher of the Stepwise Approach for Managing Asthma Long Term)? ☐ Yes ☐ No

**Allergic Rhinitis - Singulair and montelukast only**

6. Does the patient have a diagnosis of Allergic Rhinitis? ☐ Yes ☐ No
7. Does the patient have a documented failure with a 30 day trial of an inhaled nasal steroid spray AND a documented failure with a 30 day trial of a non-sedating antihistamine within the last 12 months? ☐ Yes ☐ No
8. Does the patient have a documented adverse reaction or contraindication to inhaled nasal steroids AND to non-sedating antihistamines? ☐ Yes ☐ No

**Exercise-Induced Bronchoconstriction - Singulair and montelukast Only**

9. Does the patient have a diagnosis of Exercise-Induced Bronchoconstriction? ☐ Yes ☐ No
10. Is the patient 6 years old or older and has a documented failure on a short acting bronchodilator during the last 12 months? ☐ Yes ☐ No
11. Does the patient have a documented adverse reaction or contraindication to a short acting bronchodilator? ☐ Yes ☐ No

Signature of Prescriber:_____ Date:_____

*Prescriber signature mandatory

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to CSC at: (855) 710-1964 Pharmacy PA Call Center: (866) 246-8505

Instructions for completing this form can be found at http://www.NCTracks.com/PAformhelp V.01